Editorials and Association Notes

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Abuse of Lugol's

The management of patients who have been unwisely Lugolised is an all too common problem. Either the diagnosis has been obscured by Lugol's solution in any dosage (or any other iodine compound including potassium iodide), or else a known hyperthyroid patient has been given Lugol's solution far in advance of operation, and the medication has lost its effect by the time surgery is possible. In the latter case the risk of operation is greatly increased.

The main legitimate use of Lugol's solution is its administration for ten days before operation, after the diagnosis is firmly established, and after the patient has agreed to submit to surgery. It is only common sense to leave this treatment to the surgeon responsible for the operation.

The other use of Lugol's is as a court of last resort in the differential diagnosis of a difficult case. Before it is used a careful written history should be prepared including reference to nervousness, palpitation, weight loss, appetite, bowel action, muscle power and heat intolerance. The examination should include eye signs, tremor, goitre, skin moisture and heat, pigmentation, waking and sleeping pulse rates on several occasions, and several observations of blood pressure. Helpful positive findings are a sleeping pulse rate, over 75, or a high pulse pressure. A very strong point against the diagnosis is cold moist hands and feet, particularly if bluish. The Basal Metabolic Rate should always be determined before Lugol's is given. It is stated that ten grains of quinine t.i.d. for one day will cause normal or hypothyroid patients to have slight tinnitus or deafness but will leave hyperthyroid patients unaffected. If the above conditions have been met and if operation is possible at the end of ten days, Lugol's may then be given as a therapeutic test, observing particularly its effect on weight, waking and sleeping pulse rates, B.P., heat intolerance and B.M.R.

It should be realized that the B.M.R., even when well done, is not an infallible answer to every case. Many conditions besides hyperthyroidism may increase it, and a patient with a high normal rate may actually have hyperthyroidism needing surgery.

The doctor who attempts to cure a hyperthyroid patient with Lugol's solution is wantonly risking his patient's life. —F.G.A.

Coma

(from the W. G. H. Internes' Hand Book)

Patients entering the hospital in coma are Emergencies. A life may depend on the rapidity with which a diagnosis is made and treatment instituted.

1. HISTORY—This is of paramount importance. If no friends accompany the patient, talk to the ambulance man. Then send out the police or social worker. Inquire especially about: type of onset, injury, alcohol, other poisons, infections, convulsions, headache, previous illness (diabetes, kidney trouble, high blood pressure).

2. PHYSICAL EXAMINATION— Be rapid and thorough. Remember this is essentially veterinary medicine. Your patient cannot help you. Use your eyes: note the patient's color, posture, movements; look for wounds, especially in the scalp. Examine the pupils, the eyegrounds, the eardrums, the throat. Use your nose: Is there an odour to the breath—alcohol, acetone, illuminating gas? Use your hands: Feel for a stiff neck, for fractures, for muscle and vasomotor tone in the extremities; for enlarged glands, palpate the abdomen, test the reflexes and Kernig's. Use your ears: Examine the heart and lungs. Take the temperature, pulse, respiration and blood pressure. Examine skin for needle punctures (morphine, insulin). Examine contents of pockets for syringe, medications or medical card.

3. ROENTGEN RAYS — Should be taken while the patient is on the way to the ward, unless the patient is in shock, when immediate shock treatment takes precedence over everything else. Skull plates should be taken on all injuries, and whenever the diagnosis is not evident. Other plates as indicated.

4. LABORATORY WORK — Gastric lavage for all poisonings, and severe alcoholics. Save the contents. 2. Catheterize and examine the urine as soon as possible. If reducing substances or acetone is present, and in all diabetics, do a blood sugar at once. 3. Do haemoglobin and smear. In the presence of infection take a blood culture. 4. Take blood routinely on nontraumatic cases for a Wesserman and non-protein nitrogen determinations. 5. Spectroscopy, electrocardiograph, Blood CO_2 combining power, etc., when indicated.

5. LUMBAR PUNCTURE— Routine in all injuries (except during shock), cerebral vascular accidents, convulsions, and meningeal irritation, and in all cases where the diagnosis is obscure. Note the initial pressure, colour of fluid, cell count and globulin. Remove enough fluid for Wasserman, total protein and mastic examination. When indicated, do smear, culture and chloride determinations.

In the presence of papilloedema permission to do a puncture must be obtained from a staff man. The puncture is then done with the manometer attached and the stop-cock handle turned away from the patient. When the first section of the manometer is filled with fluid the stop-cock handle is turned vertically to terminate the operation and let the manometer contents flow into the test tube.

The causes of coma in order of frequency:

1. Alcoholism, 59%.
2. Trauma, 13%.
3. Cerebral vascular lesions, 10%.
4. Poisoning (barbital or its derivatives, CO, bromides, $KMNO_4$, nitro benzene, lysol, sodium nitrite), 3%.
5. Epilepsy, 2.5%.
6. Diabetes, 2%.
7. Meningitis, 2%.
8. Pneumonia, 1.5%.
9. Cardiac decompensation, 1.5%.
10. C. N. S. Syphilis, 0.5%.
11. Uremia, 0.5%.
12. Eclampsia, 0.5%.
13. Miscellaneous (massive haemorrhage, burns, erysipelas, encephalitis, brain tumor, miliary tuberculosis, carcinomatosis, hypo glycemic shock, Stokes-Adams disease, immersion, syncope, hysteria, pernicious anemia, leukemia, ruptured ectopic pregnancy, intestinal obstruction, ruptured urethra, cholemia, empyema, septicemia), 4%.

The Manitoba Medical Service Plan

This plan has been devised after requests from various groups of employees for medical care on a prepayment basis. These requests came as a result of already established schemes such as the Winnipeg Firefighters Club, C.P.R. employees, C.N.R. employees, postal workers. Only the first of these schemes was open to the medical profession as a whole.

The Manitoba Medical Association assigned to its Committee on Economics the task of drawing up a scheme of voluntary health insurance in Manitoba. During 1941 the Committee on Economics spent much time in discussing various plans. In the fall of 1941 the Committee on Economics made a definite recommendation to the Manitoba Medical Association and this was approved by the Executive. On December 12, 1941, a meeting was held to which all Winnipeg practitioners had been invited and general approval was given to the two schemes presented, one giving complete medical care, the other surgical and obstetrical care in hospitals.

Provisional Board

A provisional board was appointed by the Manitoba Medical Association as follows: Doctors M. R. MacCharles (chairman), Brian Best, Hugh F. Cameron, J. S. McInnis, C. McRae, A. C. Abbott and Ross Mitchell. This group held several meetings. On February 7, 1942, a letter containing an outline of the two schemes and a tentative scale of fees was mailed to each physician in Greater Winnipeg with a request that within 24 hours the physician should signify his willingness, or the reverse, to enrol on the panel and to accept the stated fees.

Following this there were numerous meetings of this Committee together with Dr. H. D. Kitchen, President of the Manitoba Medical Association, the solicitor, Mr. W. C. Hamilton, K.C., and representatives of the Manitoba Hospital Service Association. After careful study it had been decided by the Committee that the Hospital Service Association, which has had such signal success, should act as agent of the Manitoba Medical Service in selling the plan and collecting dues. By-laws were drawn up, submitted to the closest scrutiny, and finally drafted. A joint meeting of the medical members of the Board of Manitoba Medical Service and the lay members, an exceptionally able group of business and labor men, was held and the by-laws were again considered. Copies of all these by-laws were mimeographed and sent to all the practitioners in Greater Winnipeg previous to a meeting of the general profession on October 30.

Agreement Finally Reached

At this meeting eight other doctors were chosen as a Law Amendments Committee: Drs. A. Hollenberg, W. G. Beaton, A. T. Gowron, J. M.

McEachern, C. G. Sheps, P. H. McNulty, C. M. Strong, and J. C. Hossack. This Committee has met with the previously named medical members of the Board of Manitoba Medical Service on several occasions. A letter under date of November 13 was sent out to all practitioners asking for criticisms, and these have been considered. Agreement has been reached and it is hoped that the scheme can be put into operation with the beginning of the new year.

A consequence of these delays, however, has been a cooling of interest on the part of some employee groups who are inclined to think that the medical profession is not genuinely concerned with any prepayment plan. A large firm has stated that it has become weary of the delays and has arranged with an insurance company to provide medical health insurance for all its employees.

The idea in the minds of the Committee on Economics was to devise a co-operative scheme which would benefit both the insured and the medical practitioners who were willing to go into the scheme. It is well known that there are smaller schemes open only to employees of certain companies and small groups of medical men. Manitoba Medical Service is open to all employees below a certain income level, now fixed at $2,400 per annum for married men, and $1,800 for single men, with medical care to be provided by any registered practitioner who wishes to become a medical member.

Advantages

One may ask what are the advantages of such a scheme.

For the employee it gives protection against the economic hazard arising from the type of illness likely to affect his standard of living. We are all acquainted with the advantages of insurance. Why should a man with a wife and young family be denied the privilege of protecting himself and his dependents against a catastrophic illness? He will be much easier in mind if he knows that medical care for himself and his dependents is provided for at a cost within his financial scope. The experience of the Winnipeg Firefighters Medical Scheme, now in its third year, is proof of this.

For the medical member it means a greater volume of work. The examination of recruits, of young people and of high school students has revealed an astonishing amount of physical unfitness, most of which is minor and easily remediable. For many, if not the majority of those examined, the cost of medical care under the old system has been prohibitive. With this barrier removed it is wholly probable that those disabled would seek relief. Also payment is assured, so that there is no necessity for haggling with patients over fees, or using the services of a collector or the courts to enforce payment.

It is admittedly an experiment, but it is an experiment which is being worked out in other provinces and in numerous States in the American republic. Surely physicians are not afraid of making a new venture. The Mayo Clinic at Rochester was a daring innovation when it was first started. One of the founders of a flourishing mutual insurance company was a medical practitioner in a small Manitoba town who for many years was president and general manager. Have initiative and co-operative enterprise disappeared from physicians of this day?

It is an open secret that the Dominion Government is considering a national scheme for health insurance. If Manitoba Medical Service can be put into effect with the new year, there will be experience gained which will be of the greatest benefit to the medical profession and the public.

Such a scheme as Manitoba Medical Service will aid our medical men who have been serving with the armed forces to re-establish themselves in practice after the war.

For the whole community there is the benefit of a co-operative enterprise without the element of profit. As patients are likely to seek relief earlier, there should be improvement in public health. It will tend to produce stability, a goal which is especially to be desired in the post-war period which is bound to be disturbed. No one wishes to see another general strike such as Winnipeg had in 1919. A community co-operative scheme like the Manitoba Medical Service will tend to prevent any such disaster.

If the proposed regulations and scale of fees are the stumbling blocks, it must be remembered that no plan can be proposed which will wholly satisfy all members of the profession. The regulations and the scale of fees are both tentative and can be modified as experience dictates. By-laws can be altered and added to meet unforeseen problems. Abandonment of the scheme should not be considered.

Ross Mitchell.

Post Graduate Course

The Post-graduate committee of the Faculty of Medicine has planned a refresher course designed for medical men in the services. The course will be held during the third week in February. Membership will be limited to medical officers of the armed forces. On Friday evening, February 19, a joint meeting of the Winnipeg Medical Society and those attending the refresher course will be held in the Physiology Theatre. A round table discussion on Peptic ulcer will be a feature of the programme.

Ambulance

The Winnipeg City Police ambulance will respond to emergency calls in the City of Winnipeg when no other ambulance service is available.

Obituaries

Dr. Thomas Alfred Martin Hughes died in Deer Lodge Hospital January 25 in his seventy-fifth year.

A veteran of the first Great War, he enlisted with the 128th Moose Jaw Battalion, and on his return from overseas in 1918 he practiced in Winnipeg until his death. He was born near London, Ont., graduated in medicine from Western University, London, in 1882, and came west about 1885. He practiced for many years at Souris before enlisting. He is survived by his widow, a son and daughter.

◈ ◈

After an illness of five years Dr. Frank M. Turner died at his home, 130 Monck Ave., Norwood, on January 24, aged 65.

Born at Albany, Ontario, he received his early education at Goderich, Ont., then attended Wesley College, Winnipeg, and University of Toronto, and returned to Winnipeg to graduate in medicine from Manitoba Medical College. After post-graduate work in New York and Boston, he practiced at Deloraine for three years and at Winnipeg and district until his illness. He is survived by his widow and a daughter.

Dr. Turner was an elder of Knox Church, Winnipeg, and a member of Northern Light Lodge, A.F. & A.M.

◈ ◈

Dr. James Thomas Adam Clarke died at his home in Winnipeg on January 23, aged 69. Born at Millbrook, Ont., he was educated at Queen's University, Kingston, where he took his Arts and part of his medical course. He graduated from Manitoba Medical College in 1901. For a time he practiced at Lauder, Man., then at Cypress River, before returning to Winnipeg.

He was a member of the board of directors of Victoria Hospital and was well known throughout the province. He is survived by two daughters.

Letter From Dr. Cox of B.M.A.

B.M.A. House, Tavistock Sq., W.C.1.

My dear Ross Mitchell: November, 1942

You will see how careful we are becoming about paper; every scrap is precious and really when one reflects that a great deal of it comes from cutting down your glorious forests one can't help thinking it is wasteful to treat paper "as a scrap of paper."

I was not only in at the birth of the "National Ophthalmic Treatment Board," but also thought it one of the best public services the B.M.A. had ever rendered to the community.

I have read all about your Annual Meeting at Jasper and it seems to have come off very well. What did you think of your own particular section?

I have just had a very cheery letter from Mrs. Harvey Smith. She was evidently very pleased that Harvey's portrait is now hanging in his "spiritual home," as it very properly should do, and she says she thinks it is a good portrait. I am so glad. Few men I have met left a greater impression on me of complete honesty of purpose and devotion to his profession, his country and his family.

Another good Canadian friend was lost when Birkett of Montreal passed on, full of honours and with a fairly good toll of years to his credit. I "fell for him" the first time I met him and we corresponded occasionally almost to the last. But I never realized what a big man he was professionally until I read the excellent Obituary in the C.M.J. And now Nicholls, another old friend is on the shelf, but not yet gone, thank goodness. I don't want to feel that all my friends with whom I have kept in touch in Canada are gone, but now there are only Bazin, and you, and Mrs. Harvey Smith and Nicholls. Routley I hear from occasionally, but he is too busy for much private correspondence. So mind you don't forget to write occasionally.

I am very lucky in my correspondents. Sir Henry Brackanbury, a great B.M.A. man, often wrote after he left London, and we had much in common—a love of books e.g. He left me a choice of anything in his library and I chose his edition of Macaulay in 12 volumes which I have thoroughly enjoyed re-reading. The essays are a perpetual joy. Then owing to the instigation of another very old friend, C. O. Hawthorne, F.R.C.P., and a distinguished B.M.A. man, I have recently re-read Boswell and found it more entrancing than ever, though it did make me feel a little less confident of Macaulay's judgment. He treats Boswell as a fool—an inspired fool, it is true—but I think he does much less than justice to a man who married subject and style perfectly. And he wasn't afraid to stick up to Johnson when he thought his idol was wrong or unjust, as he frequently was—and yet what a *man!*

What a grand thing it is that we old'uns have not only our precious memories but our books to console us for the loss of much we regret.

Well, I must not be too garrulous, so I close with my very best wishes for yourself, Mrs. Mitchell and family and may we see the end of this bloody business in 1943. Canada at any rate can be very proud of what she is doing.

Yours as usual,

ALFRED COX.

Winnipeg Medical Society

C. B. STEWART — *President*
C. M. STRONG — *Vice-President*
MEETINGS
Third Friday, each month

J. C. HOSSACK — *Past President*
DIGBY WHEELER — *Past President*
Next Meeting
February 19th

H. F. CAMERON — *Secretary*
A. T. GOWRON — *Treasurer*
MEETINGS
Start exactly at 8:15 p.m.

NOTICE BOARD

The month of January was distinguished by two things out of the ordinary. First we had an address by Brig. Chisholm on the Man Power situation, and, at the regular meeting, an address by an "Old Timer." There was a link between the two speakers. Both were standing on the cross-roads of today, but one was looking into the future; the other was looking back through the long vista of half a century.

Brig. Chisholm's job is to fit the right man to the right place—which is not always in the services. After all, the civilians have still to be looked after, especially the rural civilians, many of whom are enduring the medical privations of the pioneers. Brig. Chisholm told of the draining of rural practitioners to the cities, and left no doubt in the minds of his hearers as to his feelings towards those selfish migrants. He spoke of several things, but the essence of his address was a warning. He warned the profession against antagonizing the people. There is a loud demand for state medical care—a demand that will be granted. Unless the doctors do all in their power to win the goodwill of the people, the people will ignore the doctors when the health legislation comes to be enacted. One has only to listen to the radio discussions on health insurance to realize that the layman has no thought for the doctor except as a necessary part in the scheme.

Brig. Chisholm pointed out that already we are under government control to some extent, for no one can take a salaried position or move out of the country without the permission of the government. It is possible for our affairs to be still further controlled in little and in great ways. In union there is for us tremendous strength, but union we cannot have till every doctor is willing to set his prejudices aside and lend his whole strength to our associations. Those who remain out of the fold are already enjoying benefits which others have won for them. By remaining aloof they make it possible for every one—including themselves—to lose what we have gained. What is now a cloud no larger than a man's hand is shaping itself into a whirlwind, and against the coming storm, strong and complete union is our sole defense.

◈ ◈

More than seventy years of a busy life have neither dimmed the eye nor blunted the wit of Dr. Clingan of Virden—age cannot wither nor custom stale his infinite variety. He has been in practice for over 50 years—long enough to see medicine change from mysticism tinged with science to science tinged with mysticism. When he was a student surgery was antiseptic, "sterile preps" and rubber gloves unknown. Bacteria had arrived, he reminded us, but the "ologists" had still to come. The microscope was almost a curio. Even the stethoscope as introduced by Laennec was not of late date. X-ray was in its crudest form. Only the simplest laboratory tests were performed. The feverish sick were heaped high with blankets and no breath of fresh air allowed to touch them. Graves were opened every day for victims of diphtheria, typhoid and tuberculosis.

Through all the half-century of progress Dr. Clingan has kept pace with every advance. He has been prominent in many branches of medical effort in his district society, in the work of health officer. In addition he found time to go to France as a combatant officer and later to go to Parliament. In such a long and varied career there was much of interest and the many side glances he cast as he reviewed some of the incidents of his life were illuminated and amusing.

◈ ◈

Last month I appealed for contributions to the Overseas Fund. I am afraid that I'm not much of an appealer because only one cheque was received—for $5.00, from Dr. Thomas of Rivers. The matter, however, is of some urgency. This month we shall have to use the fees of about 50 members to send parcels to 80 members overseas. The Manitoba Medical is anxious to help, but cannot. The College of Physicians, which has between 40,000 and 50,000 dollars is prevented by law from contributing. The Society must therefore bear the load unless there are among you some who will help. John Crawford is in Hong Kong. Eddie Corrigan, Roy Richardson and others to the number of about 80 are bearing the burden and heat of the day, several of them on the dangerous waters of the high seas. The revenues that once were theirs are now enjoyed by us. No day goes past I am sure, that we do not think of them, but they do not know that unless they get some tangible evidence of our thoughts. While this is addressed to the country practitioners I hope the urban doctors will not, if they read it, pass it by.

AN ACHIEVEMENT

IN MATERIA MEDICA FROM THE '70's

It was in the '70's that Dr. Phillips first presented

Phillips' Milk of Magnesia

Palatable, effective, accepted at once as an outstanding medical discovery, it has continued through the years as one of the most widely used of standard medications, recognized as—

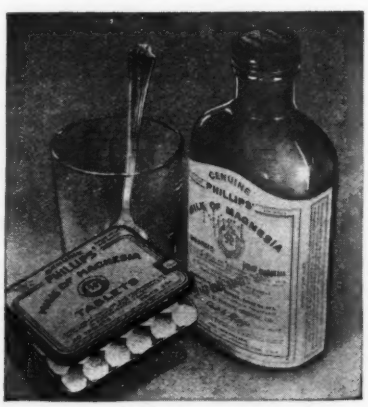
1. A reliable antacid medication, three times as effective as a saturated solution of sodium bicarbonate. No carbonates liberated, hence no CO_2 bloating; minimal acid rebound.
2. A gentle, thorough laxative with no danger of bowel irritation.

Pleasant to the taste. Especially effective for children, and wherever mild laxation is indicated.

DOSAGE:

As an antacid: 2 to 4 teaspoonfuls.
(2 to 4 Tablets)

As a gentle laxative: 4 to 8 teaspoonfuls.



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THE CHAS. H. PHILLIPS CHEMICAL CO. Windsor, Ontario

Personal Notes and Social News

Dr. and Mrs. N. W. Warner, 54 Hargrave St., are receiving congratulations on the birth of a daughter (Mary Elizabeth), on January 15th at the Winnipeg General Hospital.

◈ ◈

Dr. H. M. Speechly was elected chairman of the Advisory Traffic Commission of the City of Winnipeg.

◈ ◈

Sir William Arbuthnot Lane, grand old man of British surgery, died at his home in London on Saturday, January 16th. He was 86 and it is said he campaigned for almost everything, including cleaner beer mugs in pubs.

◈ ◈

Dr. D. F. McCrea, formerly of Ninette Sanatorium is now attached to the Central T.B. Clinic, Winnipeg.

◈ ◈

Dr. S. M. Scott, formerly associated with the Cordite plant, is now with the Dept. of Pensions and National Health at Edmonton, Alta.

◈ ◈

Drs. D. J. Hastings, W. J. M. McFetridge, J. L. Downey, G. M. Stephens, H. L. Wylie, I. J. Lazareck and B. L. Rosenfield are now serving in His Majesty's Forces.

◈ ◈

Dr. R. Brodie Anderson, formerly with the Cordite plant, is now practicing in Winnipeg.

Dr. E. A. Jones, formerly associated with Dr. M. R. MacCharles, is now a Flight Lieutenant in the R.C.A.F.

◈ ◈

The Men in the Forces Need Magazines—Mrs. H. Douglas McLaughlin, chairman of the Imperial Order Daughters of the Empire magazine committee asks us to remember the need of reading material by dropping magazines in the bins on the street corners or phoning 24 181 for pick-up. These magazines go to the navy, army, air force and merchant marine.

◈ ◈

Flt. Lieut. and Mrs. David B. Stewart are receiving congratulations on the birth of a daughter (Elva Ruth) on January 13th, 1943, at the Winnipeg General Hospital.

◈ ◈

Dr. Magnus Hjalsson formerly of Winnipeg is now located in Glenboro, Man.

Oddities in the News

The following item appeared in a local newspaper January 19th: "Ottawa, Jan. 19th (CP)—The Canadian Medical Association siege of Leningrad and the capture of Schusselburg have properly put the wind up of both the Finns and Swedes according to reports reaching here." Spreading an epidemic of jitters is not in keeping with the oath of Hippocrates.

Department of Health and Public Welfare

The Prevention and Control of Typhoid Fever

by Maxwell Bowman, M.D.

Delving into the Statistical Records of Manitoba we find that in 1910 there were 174 deaths certified as due to typhoid* fever, in 1911, 117; in 1912, 136; 1913, 89; 1914, 66; 1915, 46; 1916, 43; 1917, 31. As the case fatality rate of typhoid holds steadily around 10% each of these deaths represents about ten cases. In 1918 reporting of cases was started—190 cases, 40 deaths—obviously not complete reporting of cases. In fact it was not until 1930 that case reporting became anywhere near on a par value with that of deaths. The deaths 1919 to 1940 inclusive were: 46, 49 ,43, 32, 30, 22, 23, 27, 27, 21, 28, 12, 15, 14, 17, 15, 12, 17, 10, 11, 16 and 18. The last two of these were 1939 and 1940 and epidemics had occurred in both years. In 1941 there were 41 cases reported and only one death; in 1942, 39 cases and three deaths.

This decrease in number of cases and deaths is marked and most gratifying. To what is it due? First of all to a safe chlorinated water supply in Winnipeg, St. Boniface and suburban municipalities, and in Brandon and Portage la Prairie. Second, to a better control of milk supplies and more use of pasteurization. Third, to some improvement in sanitation and personal hygiene, better reporting of cases and investigation and control of the sources of these.

Typhoid fever is a communicable disease and in nature attacks humans only. Therefore it should be controllable. The infection enters the body through the mouth and leaves mainly in the discharges from the bowel and kidneys, perhaps to a small degree in the sputum and other discharges. It is spread chiefly by indirect contact through water, ice, food (including milk and milk products), dishes, cutlery and fomites infected by the discharges from cases and carriers and to some extent by direct contact with cases and carriers. Flies, vermin and rodents may spread infection through contact with infected discharges.

It is quite evident then that typhoid is a disease due to faulty hygiene and sanitation. This gives us the key to prevention. Simple, isn't it?

We have seen above how the cities are taken care of, but have you visited one of the average or poorer than average rural homes in Manitoba? Did you take careful note of the well, its location, construction and protection against contamination? The privy, its construction, fly and rodent proofing, disinfection of contents, etc.? Is it used by all the men and hired help? If not, what provision is made for their sanitary requirements? Prevalence of flies in the kitchen, store rooms and dining-room? Provision for washing and bathing and proper disposal of bath and waste water? If you did, I am sure that you, with your knowledge of the spread of infection, were greatly disappointed in what you found! All that is needed to start an outbreak of typhoid in most of these homes is a visit from an ambulant case or careless carrier!

Why are such conditions allowed to exist? Properly constructed wells and privies cost money — so does their maintenance and repair. Money has not been too plentiful in rural areas, but perhaps **lack of education** regarding these health matters and **lack of interest** have been the chief obstacles. The answer given to questions as to why the well and privy are not properly constructed and maintained often is "They have been in the same condition for the past twenty to fifty years and we didn't get typhoid, so why should we now? If it's going to cost money we'll take a chance and leave it as it is!" The Department of health and Public Welfare distributes pamphlets, gives radio talks and some personal instruction **but** Health Education is a large problem. Some improvement in sanitation is taking place but not nearly enough to provide reasonable safety.

No Health Officer alone can eliminate typhoid fever from a city or community. It requires the help of all the doctors, nurses, sanitarians and the citizens themselves.

General Preventative Measures

(1) Safe and proper disposal of all human excreta.

(2) Education as to good personal hygiene. (If these two were perfect there would be no more typhoid.)

(3) Properly controlled, protected and chlorinated water supply.

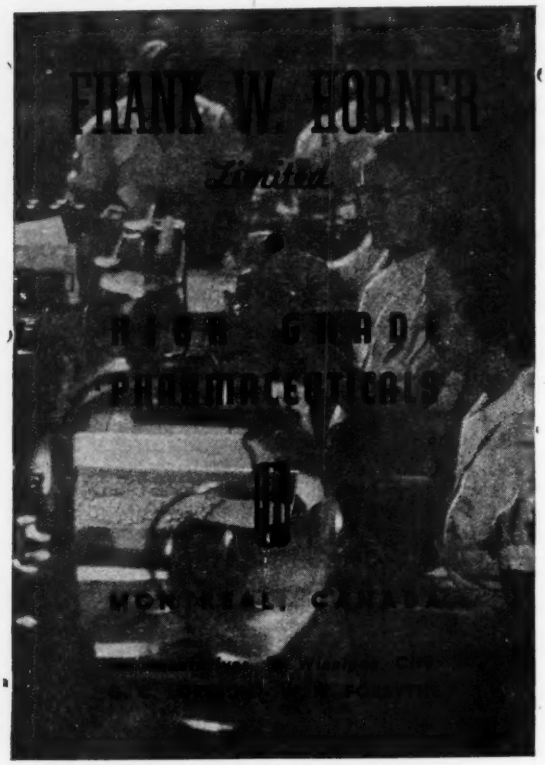
(4) Use of pasteurized milk only, produced and handled in a clean manner. (Pasteurization may be done in a double boiler...

(5) Clean, protected, cooked food. Foods eaten raw require special protection from contamination (vegetables, shellfish, etc).

(6) Suppression or exclusion of flies, vermin and rodents.

Specific Preventative Measures

(1) Carriers to be controlled, supervised and instructed regarding hygiene and sanitation. They must not be allowed to act as cooks or food handlers.



(2) Early diagnosis and immediate reporting of all cases and suspect cases to the proper authorities.

(3) All cases and suspect cases to be isolated immediately, best in hospital.

(4) Inspection of home as soon as possible and instruction of residents as to hygiene, sanitation and disinfection.

(5) Vaccination of all contacts with T.A.B. vaccine. Also of all persons camping or going into areas where a safe water and food supply are not assured.

(6) Ascertain the source of all cases and take necessary steps regarding them as cases or carriers.

Under the Regulations of "The Public Health Act" it is the **duty** of every physician to report cases of Communicable Diseases to the Medical Officer of Health and pending his action to secure the isolation of the patient and to take such action as is required under the Regulations. It is also his duty to report deaths from Communicable Disease to the Minister. These are his duties, but as a physician he has a **responsibility** to his fellow-man that he use his knowledge to teach and instruct in order that hygiene and sanitation may be so improved as to prevent the spread of typhoid and similar infections. The Health Officer's duties are set out more specifically in the Regulations but if he does not receive the able, intelligent assistance of every physician his efforts cannot accomplish the ends desired.

The Department maintains on its staff an epidemiologist and qualified sanitary inspectors. These are available for your assistance at any time. A register of typhoid carriers is kept, also a register of every typhoid case reported in Manitoba since records have been kept. As every case is a possible carrier this register is of great value in indicating possible sources. (About 2% of all cases become chronic carriers.) No case should be released from isolation in the hospital or home before Laboratory tests on **two** specimens each of stool and urine, taken **one week apart**, are found negative for typhoid. This is a **minimum** — more weekly specimens are advisable.

Typhoid fever can be wiped out if every doctor, nurse and citizen makes it his or her business to assist the Health Officer in promoting the better understanding of Communicable Disease and its modes of spread, thereby assuring better hygiene and sanitation.

* in this article includes para-typhoid fever.

Efficiency Award

Winthrop Chemical Co. Inc. are extremely proud to announce that they have been awarded the U.S. Army and Navy Insignia "E" for efficiency in the production of Medical Specialties for the Allied Forces.

Department of Health and Public Welfare

Comparisons Communicable Diseases—Manitoba

(Whites Only)

DISEASES	1942 Dec. 3 to Dec. 31	1942 Nov. 5 to Dec. 2	1941 Dec. 3 to Dec. 31	1941 Nov. 5 to Dec. 2	TOTALS Jan. 1 to Dec. 31, 1942	TOTALS Jan. 1 to Dec. 31, 1941
Anterior Poliomyelitis	2	3	4	1	65	1007
Chickenpox	396	266	356	249	2512	2229
Diphtheria	23	30	17	27	261	179
Diphtheria Carriers	1	7	7	7	39	27
Dysentery—Amoebic	.....	.....	.....	.....	.....	.....
Dysentery—Bacillary	.....	3	.....	.....	14	3
Erysipelas	2	9	7	6	91	75
Encephalitis	.....	2	1	4	40	515
Influenza	14	17	80	11	231	316
Measles	38	17	166	74	4401	3406
Measles—German	3	.....	12	16	263	1443
Meningococcal Meningitis	1	1	3	4	25	56
Mumps	267	136	210	196	3172	1447
Ophthalmia Neonatorum	.....	.....	1	.....	1	3
Pneumonia—Lobar	5	5	10	13	100	118
Puerperal Fever	.....	.....	1	.....	2	8
Scarlet Fever	47	68	91	75	1283	546
Septic Sore Throat	.....	1	4	2	59	19
Smallpox	.....	.....	.....	.....	.....	.....
Tetanus	.....	.....	.....	.....	3	1
Trachoma	.....	.....	1	1	5	8
Tuberculosis	26	57	93	52	571	599
Typhoid Fever	1	2	4	.....	34	33
Typhoid—Paratyphoid	.....	.....	.....	.....	3	1
Typhoid Fever Carriers	.....	2	.....	.....	3	1
Undulant Fever	.....	1	.....	2	11	5
Whooping Cough	117	123	23	35	693	288
Gonorrhoea	110	115	68	89	1257	1044
Syphilis	53	74	37	42	696	466

This period finishes the year 1942 so it is interesting to compare this year with 1941. It must be remembered that the figures for 1941 are complete but those for 1942 are only preliminary. Many late reported cases will be added.

POLIOMYELITIS—Did not reach epidemic proportions. Was this because the 1941 epidemic was so widespread that very few non-immunes were left to be infected.

DIPHTHERIA—Has increased in 1942—both in cases and carriers. Manitoba's report is much less favourable than that of Ontario, Saskatchewan, Minnesota and North Dakota.

BACILLARY DYSENTERY—Has been reported more than last year. We doubt that there has been any increase in cases.

ENCEPHALITIS—Only 40 cases but 17 of them died, a case fatality rate of 42.5 compared with 15.3 in 1941.

MENINGOCOCCAL MENINGITIS—In Manitoba is less than half the number in 1941. Ontario shows a higher four-weekly rate.

MUMPS—Have been epidemic in Manitoba.

OPTHALMIA NEONATORUM—Only one case reported in Manitoba in 1942!

PUERPERAL FEVER—Only two cases reported in Manitoba in 1942!

SCARLET FEVER and SEPTIC SORE THROAT— Both were more prevalent in 1942.

TUBERCULOSIS—No significant change. All open infectious cases should be confined in Sanitoria.

TYPHOID and PARATYPHOID—Again in 1942 we have been fortunate.

UNDULANT FEVER—More cases reported in 1942, probably many mild missed cases as well. What about pasteurization of all milk?

WHOOPING COUGH—Shows an increase over 1941.

SYPHILIS and GONORRHOEA—Both show an increase. This with Armed Forces and civilian travel was to be expected. Increased vigilance and effort will be required to control Venereal disease.

DEATHS FROM COMMUNICABLE DISEASE
November, 1942

URBAN—Cancer 48, Pneumonia Lobar 7, Pneumonia (other forms) 8, Syphilis 6, Influenza 3, Whooping Cough 2, Lethargic Encephalitis 1, Scarlet fever 1, Hodgkin's Disease 1. Other deaths under 1 year 15. Other deaths over 1 year 174. Stillbirths 11. Total 277.

RURAL—Cancer 44, Pneumonia Lobar 5, Pneumonia (other forms) 12, Tuberculosis 11, Influenza 3, Syphilis 3, Lethargic encephalitis 2, Septicemia 2, Diphtheria 1, Measles 1, Whooping Cough 1. Other deaths under 1 year 32. Other deaths over 1 year 238. Stillbirths 17. Total 372.

INDIANS—Tuberculosis 17, Pneumonia Lobar 1, Pneumonia (other forms) 16, Puerperal Septicemia 2, Dysentery 1, Chickenpox 1. Other deaths under 1 year 8. Other deaaths over 1 year 11. Total 57.

DISEASE	Manitoba Dec. 3-Dec. 31 *722,447	Ontario Nov. 29-Dec. 26 *3,752,000	Saskatchewan Nov. 29-Dec. 26 *940,000	Minnesota Nov. 29-Dec. 26 *2,792,300	North Dakota Nov. 29-Dec. 26 *641,935
Anterior Poliomyelitis	2	1	.....	2	1
Meningococcal Meningitis	1	16	2	1	.....
Chickenpox	396	1533	360	239	.....
Diphtheria	23	5	8	18	4
Dysentery Amoebic	.....	.....	.....	3	.....
Erysipelas	2	4	6	3	13
Influenza	14	1	.....	5	41
Leth. Encephalitis	.....	.....	1	.....	.....
Measles	38	513	213	22	3
German Measles	3	34	6	.....	.....
Mumps	267	2567	301	.....	10
Scarlet Fever	47	369	73	284	42
Septic Sore Throat	.....	1	.....	.....	.....
Tetanus	.....	1	.....	.....	.....
Trachoma	.....	.....	.....	.....	1
Tuberculosis	26	207	39	31	16
Typhoid Fever	1	2	.....	5	.....
Typhoid Para-Typhoid	.....	2	1	.....	.....
Undulant Fever	.....	2	.....	.....	2
Whooping Cough	117	370	20	191	61
Diphtheria Carrier	1	.....	.....	.....	.....
Gonorrhoea	†65	429	.....	.....	25
Syphilis	†42	426	.....	.....	26

*Approximate Populations.

†Dec. 3 to 23, 1942, only.